Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RIVER RANCH RADIOLOGY
SUITE D1
711 WEST 38TH STREET
AUSTIN TX 78705

Respondent Name
STARBUCKS CORP

Carrier's Austin Representative
Box Number 48

MFDR Tracking Number
M4-11-2231-01

MFDR Date Received
March 3, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per your Explanation of Benefits payment was disallowed for above date of service, the reason given was 'Duplicate Claim/Service.' Services are not duplicate they are 'Outside/Over-Read.' It also appears that modifier was missing, which we have added. We are resubmitting claim and respectfully requesting reimbursement for the services provided."

Amount in Dispute: $510.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have escalated the bill for additional review and it remains in process at this time. We will submit a supplemental response upon completion of the pending review. The carrier will contact the provider to discuss resolution and withdrawal of the MDR once the bill processing has been finalized. The carrier will file a supplement response with TDI once the additional review of the bill has been completed."

Response Submitted by: Gallagher Bassett Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 23, 2010	76140 x 3	$510.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W1 – Distinct service
   - 45 – Charges exceed your contracted/legislated fee arrangement
   - BL – To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests...
   - 18 (18) – Duplicate claim/service

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the requestor bill for three different reviews of two x-rays and one MRI?
3. Did the insurance carrier reimburse the requestor pursuant to 28 Texas Administrative Code § 134.203 (c)?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced disputed services with reason code "45 – Charges exceed your contracted/legislated fee arrangement." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on June 29, 2011, the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code § 134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor seeks reimbursement for CPT code 73140 defined by the AMA CPT Code book as follows; "Consultation on X-ray examination made elsewhere, written report." The requestor billed three charges of CPT code 73140 on three separate bills for date of service April 23, 2010. Review of the CMS-1500s indicates above each date of service the following; "ZZMR C-SPINE DOS 6/23/09, ZZX-RAY C-SPINE DOS 8/12/09, ZZX-RAY C-SPINE DOS 11/18/09", to indicate that three separate documents were read on one date of service.

   Review of the submitted documentation supports that the requestor billed for the disputed charges, as a result, the disputed charges are reviewed pursuant to 28 Texas Administrative Code § 134.203 (c).
3. Per 28 Texas Administrative Code § 134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   Per 28 Texas Administrative Code § 134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   The insurance carrier issued payment in the amount of $170.00 on May 11, 2011, under check #0085698710.

   The MAR reimbursement for CPT code 73140-59 is $42.60 x 3, which results in a total recommended amount of $127.82. The insurance carrier issued payment in the amount of $170.00, as a result, the requestor is not entitled to additional reimbursement for CPT code 73140-59 x 3 for review of "ZZMR C-SPINE DOS 6/23/09, ZZX-RAY C-SPINE DOS 8/12/09, ZZX-RAY C-SPINE DOS 11/18/09."
4. Review of the submitted documentation finds that the requestor is not entitled to additional reimbursement for the disputed CPT code 73140-59 x 3.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		November 7, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.